- ❑ Initiate Waiver services
- ❑ Service Modification
  - ☐ Add a service
  - ☐ Increasing amount/hours of service
  - ☐ Decreasing amount/hours of service
- ❑ Procedure Code Modification (requires 2 ISARs)
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver
Personal Emergency Response System
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED	AMOUNT REQUESTED	OMR USE ONLY
☐ S5160 - Personal Emergency Response System Installation		
☐ S5160 U1 - PERS & Medication Monitoring Installation		
☐ S5185 - PERS & Medication Monitoring (physician ordered)		
☐ S5161 - PERS Monitoring	_____ mos/year	
☐ H2021 TD - PERS Nursing Services (RN)	____ X .5hr = ___hrs/wk	
☐ H2021 TE - PERS Nursing Services (LPN)	____ X .5hr = ___hrs/wk	

Reason for this request

Individual lives alone/is alone for significant parts of the day: ____ YES ____ NO

Check the following regarding the PERS:

☐ Capable of being activated by a remote wireless device and being connected to the individual's phone line.

☐ Provides hands-free voice-to-voice communication with the response center.

☐ Activating device is waterproof, automatically transmits to the response center, signals low battery and can be worn by the individual

☐ Will be tested at least monthly to assure remains operational

☐ The PERS provider agrees to instruct the individual, family, caregiver and responders as described below: _____

Additional information:

Comments:

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/Case Manager (print) Signature Phone No. Fax No. Date